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Monkeypox

The World Health Organization has declared the global monkeypox outbreak a public health emergency of international concern. There is also concern because the disease is endemic in central and western Africa, and is not typically seen in the United States. Monkeypox is an uncommon infection caused by the monkeypox virus, which is similar to the virus responsible for smallpox. Monkeypox is rarely fatal and does not cause severe disease as smallpox does. However, individuals with compromised immunity may become acutely ill. Monkeypox is passed through person-to-person disease transmission. Vaccines that were developed to protect against smallpox viruses are now being used to prevent monkeypox infections, since the viruses are genetically similar. The following Q&A's regarding monkeypox have been developed to assist coding professionals in assigning the appropriate codes for monkeypox.

Question:

What is the appropriate ICD-10-CM code to report monkeypox?

Answer:

Assign code B04, Monkeypox, for monkeypox infection.

Question:

Now that there is a public health emergency for monkeypox, will coding professionals follow the same rules for reporting monkeypox as we did for COVID?

Answer:

No. *Official Guidelines for Coding and Reporting for COVID-19* infection were developed specifically for COVID-19 reporting

and are not applicable to monkeypox. At the start of the pandemic, the classification did not provide a specific code for COVID-19 infection. However, ICD-10-CM provides a unique code to identify monkeypox.

Currently, there are no specific coding guidelines for monkeypox. Therefore, continue to follow the *Official Guidelines for Coding and Reporting* for diagnostic coding for inpatient and outpatient services. Assign the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the encounter.

Question:

An asymptomatic patient presented to the clinic after being exposed to someone with an active monkeypox infection. How should this be reported?

Answer:

Assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, to report exposure to monkeypox.

Question:

A patient presents for follow-up after being treated for monkeypox, and the provider documented that the lesions have healed and the patient is no longer infectious. How should this encounter be coded?

Answer:

Assign code Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, as the first-listed diagnosis. Code Z86.19, Personal history of other infectious and parasitic diseases, should be assigned as a secondary diagnosis for the history of monkeypox infection.

Ask the Editor

Question:

A patient underwent an open aortoiliac aneurysm repair. During the procedure, the aortoiliac bifurcation was dissected free down to the iliac bifurcation points. Both common iliacs were noted to be densely calcified with a palpable stent in the right common iliac and an aneurysm in the left common iliac. At the left iliac bifurcation, the external and internal iliac arteries were separately dissected free. The infrarenal abdominal aorta was dissected free, skeletonized and circumscribed. The aneurysm was opened. A Dacron bifurcation graft was sewn end-to-end to the infrarenal abdominal aorta. Next, the left common iliac bifurcation was endarterectomized to enable suture to this bifurcation. The right limb of the Dacron graft was tunneled anatomically beneath both ureters, down to the right groin and sewn end-to-side to an arteriotomy in the common femoral artery. Flow was restored to the internal iliac on the left and the profunda femoris on the right. What are the appropriate ICD-10-PCS codes for the aortoiliac aneurysm repair? In this case, would replacement or bypass be assigned as the root operation or a combination of these root operations?

Answer:

Assign the following codes:

- | | |
|----------------|--|
| 04R00JZ | Replacement of abdominal aorta with synthetic substitute, open approach |
| 04RD0JZ | Replacement of left common iliac artery with synthetic substitute, open approach |

04100JH

Bypass abdominal aorta to right femoral artery with synthetic substitute, open approach

This procedure supports the root operations “Replacement” and “Bypass,” as the abdominal aorta and left iliac artery were cut or transected, and synthetic material (Dacron graft) was used to take the place and/or function of these body parts.

In this case, the surgery also involved altering the route of passage, as there is tunneling of the right limb of the graft past the iliac branches and down to the common femoral. This is an alternate route of passage for the right side.

Question:

The patient presented for elective laparoscopic sleeve gastrectomy. The provider documented in the discharge summary, “Clinically severe obesity (BMI 35.67) and metabolic syndrome,” as the reason for admission. The instructional note at code E88.81, Metabolic syndrome, states “Use additional codes for associated manifestations, such as: obesity (E66.1-).” Would the note apply when the reason for admission is bariatric surgery due to severe obesity? In this case, what condition is sequenced as principal diagnosis, metabolic syndrome versus morbid obesity?

Answer:

Assign code E88.81, Metabolic syndrome, as the principal diagnosis. Assign codes E66.01, Morbid (severe) obesity due to excess calories, and Z68.35 Body mass index [BMI] 35.0-35.9, adult, as additional diagnoses. The instructional note “Use additional code for associated manifestations” at code E88.81 indicates the proper sequencing of metabolic syndrome with obesity (etiology followed by the manifestation).

Although there is not a “code first note” at category E66-, Overweight and obesity, the coding instruction at code E88.81 must be followed.

Question:

A patient who was recently hospitalized for jaundice returns with complaints of overall itching and jaundice. The patient is diagnosed with benign recurrent intrahepatic cholestasis (BRIC). Liver biopsy as well as a serological work-up are nonrevealing as to the cause of BRIC. What is the appropriate ICD-10-CM diagnosis code for BRIC?

Answer:

Assign codes E80.6, Other disorders of bilirubin metabolism, and K76.89, Other specified diseases of liver, to fully capture the patient's condition.

Cholestasis is a condition that impairs the release of bile (a digestive fluid) from the liver. BRIC is a rare genetic disorder which causes intrahepatic cholestasis, with impaired release of bile from liver cells, resulting in bile build up in the liver, which impairs liver function. One component of bile is bilirubin, and it can accumulate with cholestasis. The symptoms of BRIC typically begin with severe itching, followed by jaundice a few weeks later due to excess bilirubin. Other symptoms may include malaise, irritability, nausea, vomiting, and a lack of appetite. BRIC is divided into two types, BRIC1 and BRIC2. BRIC can lead to progressive familial intrahepatic cholestasis (PFIC), which is a more severe form of liver disease. BRIC and PFIC are part of a spectrum of intrahepatic cholestasis disorders with different levels of severity.

Question:

A 38-year-old female presents to the Radiology Department for a right breast ultrasound. The reason for the test is documented as “lump or mass in breast.” The final ultrasound impression demonstrates, “Stable elongated hypoechoic foci adjacent to the implant in the area of the palpable lump/thickening noted clinically, these findings are benign-appearing and stable.” Is it appropriate to assign a code for a condition of the breast, when a patient is status post bilateral mastectomies? What are the correct codes assigned for this outpatient encounter?

Answer:

Assign code R22.2, Localized swelling, mass and lump, trunk, for the mass/lump/thickening in the area of the right mastectomy site. Also assign codes Z90.13, Acquired absence of bilateral breasts and nipples, and Z98.82, Breast implant status. Although “lump or mass in breast” is documented as the reason for the ultrasound, code N63.10, Unspecified lump in right breast, unspecified quadrant, is not appropriate since both breasts have been surgically removed.

Question:

The patient developed a partially obstructing blood clot in the right main bronchus that was successfully removed during bronchoscopy. Would this clot be coded as a pulmonary embolism?

Answer:

Assign code J98.09, Other diseases of bronchus, not elsewhere classified, for a partially obstructing blood clot in the right main bronchus. The clot in the bronchus is not a pulmonary embolism because it did not involve

pulmonary vessels. A pulmonary embolism is defined as a blockage in the pulmonary vasculature, which is typically caused by a blood clot.

Question:

A patient with a past medical history of skin melanoma, and known metastases to the brain and lung, presented with right lower facial droop, aphasia and dysarthria. The provider's diagnostic statement listed, "Intracerebral hemorrhage of known brain metastases, and vasogenic edema, likely causing the patient's presenting symptoms." The patient improved with the initiation of steroids. What are the appropriate code assignments and sequencing for this admission?

Answer:

Sequence either code I61.9, Nontraumatic intracerebral hemorrhage, unspecified, or code G93.6, Cerebral edema, as the principal diagnosis. Codes C79.31, Secondary malignant neoplasm of brain, C78.00, Secondary malignant neoplasm of unspecified lung, R29.810, Facial weakness, R47.01, Aphasia, R47.1, Dysarthria and anarthria, and Z85.820, Personal history of malignant melanoma of skin, should be assigned as additional diagnoses.

The presenting symptoms of facial droop, aphasia and dysarthria were due to the intracerebral hemorrhage and vasogenic cerebral edema. When an encounter is for management of a complication associated with a neoplasm and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm. This is consistent with the *Official Guidelines for Coding and Reporting*, section I.C.2.I.4.

Question:

A patient with known adenocarcinoma of the lower third of the esophagus was admitted with ataxia and double vision. Work-up revealed new brain hemorrhage and brain metastases as the cause of the patient's symptoms. The patient underwent surgical resection of the metastatic brain lesion. What is the appropriate code assignment and sequencing for this admission?

Answer:

Assign code C79.31, Secondary malignant neoplasm of brain, as principal diagnosis since the metastatic brain lesion was excised. Codes I61.9, Nontraumatic intracerebral hemorrhage, unspecified, C15.5, Malignant neoplasm of lower third of esophagus, R27.0, Ataxia, unspecified, and H53.2, Diplopia, should be assigned as additional diagnoses.

In this case, although the hemorrhage is a complication of the cerebral brain metastasis, surgical treatment was directed to the brain metastasis (by excision) and not primarily to the hemorrhage.

Question:

A patient with known left breast cancer metastatic to the brain presented to the emergency department with altered mental status (AMS). Diagnostic imaging revealed stable metastatic brain cancer with increased vasogenic cerebral edema. At the time of discharge, the provider suspected that the progressive cerebral edema around known metastatic brain lesions was contributing to the patient's AMS, which improved with steroid therapy. What are the appropriate code assignments and sequencing for this admission?

Answer:

Assign code G93.6, Cerebral edema, as principal diagnosis. Codes C79.31, Secondary malignant neoplasm of brain, and C50.912, Malignant neoplasm of unspecified site of left female breast, should be assigned as additional diagnoses.

The presenting symptom of AMS was due to the vasogenic cerebral edema. When an encounter is for management of a complication associated with a neoplasm and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm. This is consistent with the *Official Guidelines for Coding and Reporting*, section I.C.2.I.4.

Question:

A patient who is status post right above-the-knee amputation and placement of an osteointegrated implant, returns for corrective surgery. A medial thigh lift was performed due to soft tissue envelope redundancy and ulcerations around the implant. What is the appropriate diagnosis code assignment for soft tissue envelope redundancy and ulcerations around the osteointegrated implant?

Answer:

Assign codes T87.89, Other complications of amputation stump, and L98.7, Excessive and redundant skin and subcutaneous tissue, for the soft tissue redundancy at the site of the amputation.

Question:

The above patient underwent right medial thigh lift and elliptical excision of skin from the stoma on the lateral side due to soft tissue envelope redundancy and ulcerations around the osteointegrated implant. To perform the medial

thigh lift, skin and subcutaneous tissue were excised from the medial thigh. Redundancy of the adductor muscles was reduced by dividing superficial anterior and posterior attachments and transposing the rectus femoris and biceps femoris from lateral to medial, over the adductor muscles. The medial lift was further advanced by exposing the medial aspect of the thigh through an incision along the groin crease; a fasciocutaneous thigh flap was preserved on the medial perforators from the superficial femoral artery, advanced cranially and sutured to the pubic tubercle and inguinal ligament. An elliptical excision of skin from the stoma and tailor tack suture closure to tighten the skin and subcutaneous tissue on the lateral side was performed. The skin and subcutaneous tissues were divided and advanced to tighten the subcutaneous tissue. What are the procedure code assignments for the procedures performed?

Answer:

Assign the following codes:

- | | |
|----------------|--|
| 0KSQ0ZZ | Reposition right upper leg muscle, open approach, |
| 0KSQ0ZZ | Reposition right upper leg muscle, open approach, for transposition of the rectus femoris and biceps femoris to tighten the musculature, |
| 0JXL0ZZ | Transfer right upper leg subcutaneous tissue and fascia, open approach, for the medial lift advancement of the fasciocutaneous flap to the pubic tubercle and inguinal ligament, and |

0JBL0ZZ

Excision of right upper leg subcutaneous tissue and fascia, open approach, for excision of the skin and subcutaneous tissue, from the lateral surgical site.

The transposition of the rectus femoris and biceps femoris is consistent with the ICD-10-PCS definition of Reposition—“Moving to its normal location, or other suitable location, all or a portion of a body part.” Transfer is defined by ICD-10-PCS as ‘Moving, without taking out, all or a portion of a body part to another location to take over the function of all or a portion of a body part’ and the thigh muscles are not taking over the function of another body part.

Question:

A 38-year-old patient was admitted due to prolapsed and nonhealing necrotic neovaginal skin graft, six days status post gender reassignment surgery, involving penile inversion vaginoplasty. What is the appropriate diagnosis code assignment for the neovaginal graft complications?

Answer:

Assign code T83.89XA, Other specified complication of genitourinary prosthetic devices, implants, and grafts, initial encounter, for the prolapsed neovaginal graft. Code I96, Gangrene, not elsewhere classified, should also be assigned to describe the necrotic portion of the skin graft.

Question:

This same patient underwent repair of the prolapsed and nonhealing necrotic neovaginal graft, six days status post gender reassignment surgery. At surgery, the nonviable skin graft was removed and the neovagina was closed

by suture of the external anal sphincter to the bulbospongiosus muscle. Zero depth vaginoplasty was performed, vulvar skin was excised and bleeding edges were advanced to create a dimple to replace the vaginal introitus. What procedure codes should be assigned for the zero depth vaginoplasty and feminizing vulvoplasty?

Answer:

Assign the following procedure codes:

- | | |
|----------------|--|
| 0HX9XZZ | Transfer perineum skin, external approach, for the zero depth vulvoplasty; |
| 0UPH77Z | Removal of autologous tissue substitute from vagina and cul-de-sac, via natural or artificial opening; and |
| 0KQM0ZZ | Repair perineum muscle, open approach for the closure of the neovagina. |

Question:

A patient was admitted with recurrent malignant pleural effusion, and thoracentesis with placement of a PleurX™ catheter was performed. Pleural fluid cytology was positive for cancer cells. The patient has a past history of left breast cancer and at that time underwent a lumpectomy. More recently, she was diagnosed with invasive ductal carcinoma of the left breast ER/PR positive, HER2 negative, and had a bilateral mastectomy. The patient also has known metastases to the cervical lymph nodes, liver and bone, and is on adjuvant Tamoxifen therapy. Would it be appropriate to assign code J91.0, Malignant pleural effusion, as the principal diagnosis? The instructional note at code J91.0 directs “Code first the underlying neoplasm.”

Answer:

No. It is not appropriate to assign code J91.0, Malignant pleural effusion, as principal diagnosis, because of the instructional note, “Code first underlying neoplasm.” Assign code C50.912, Malignant neoplasm of unspecified site of left female breast, as the principal diagnosis since the patient is still receiving adjuvant treatment for the breast cancer. Assign codes J91.0, Malignant pleural effusion, C77.0, Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck, C78.7, Secondary malignant neoplasm of liver and intrahepatic bile duct, C79.51, Secondary malignant neoplasm of bone, Z17.0, Estrogen receptor positive status [ER+], and Z79.810, Long term (current) use of selective estrogen receptor modulators (SERMs), as additional diagnoses.

The Official Guidelines for Coding and Reporting state, “Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.”

Question:

The patient has been diagnosed with myasthenia gravis and also with dialysis dependent end stage renal disease secondary to type 2 diabetes mellitus (DM). When following the Index to Diseases under DM with myasthenia, one arrives at code E11.44, Type 2 diabetes mellitus with diabetic amyotrophy.

Does ICD-10-CM presume a relationship between DM and myasthenia gravis since the terms diabetes and myasthenia are linked by “with” in the Index? Research seems to indicate that myasthenia gravis and diabetic amyotrophy are separate conditions. How should this case be coded?

Answer:

Assign code G70.00, Myasthenia gravis without (acute) exacerbation. Also, assign codes E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease, N18.6, End stage renal disease, and Z99.2, Dependence on renal dialysis. Diabetic amyotrophy is not the same as myasthenia gravis, and the two conditions are not automatically linked by the classification. The health record documentation does not support diabetic amyotrophy, a history of any neurological issues, muscle weakness related to the diabetes, or any condition that would merit assignment of any code from subcategory E11.4-, Type 2 diabetes mellitus with neurological complications.

Question:

The patient is a 49-year-old who presented for heart transplantation surgery because of end stage heart failure due to peripartum cardiomyopathy which developed four years postpartum. The *Official Guidelines for Coding and Reporting* state that the peripartum period is defined as the last month of pregnancy to five months postpartum. The guidelines also state that chapter 15 codes may also be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider documents that a condition is pregnancy related. In this case, would it be appropriate to assign code O90.3, Peripartum cardiomyopathy, years after the postpartum

period or should O94, Sequela of complication of pregnancy, childbirth and the puerperium, be assigned?

Answer:

Assign codes I50.84, End stage heart failure, O94, Sequela of complication of pregnancy, childbirth and the puerperium, and O90.3, Peripartum cardiomyopathy. In this case, the heart failure is the sequela of the peripartum cardiomyopathy. The specific nature of the late effect/residual condition (i.e., heart failure) is sequenced first, followed by code O94. In addition, code O90.3 is assigned to capture the fact that the cardiomyopathy occurred in the peripartum period. Assigning a code for peripartum cardiomyopathy along with a code describing sequela of pregnancy, childbirth and the puerperium does not conflict with the *Official Guidelines for Coding and Reporting* for sequela. The peripartum cardiomyopathy is a chronic condition/effect that is continuing now, which can be coded when the condition starts in the peripartum period and persists years later. Codes are assigned for the peripartum cardiomyopathy as well as for sequela to capture two different issues.

Question:

A 43-year-old female was transferred to our facility for treatment of end-stage ischemic cardiomyopathy due to peripartum spontaneous coronary artery dissection (SCAD) that occurred more than ten years ago. She is status post coronary artery bypass graft (CABG) surgery, extracorporeal membrane oxygenation (ECMO) and left ventricular assist device (LVAD) placement in 2010 as a bridge to heart transplantation. Since the provider documented that the ischemic cardiomyopathy is due to peripartum SCAD, would codes

O90.3, Peripartum cardiomyopathy and O94, Sequelae of complication of pregnancy, childbirth and the puerperium, be assigned?

Answer:

In this case, the patient had peripartum SCAD, which led to end-stage ischemic cardiomyopathy. She did not have peripartum cardiomyopathy. Assign codes I25.5, Ischemic cardiomyopathy, and O94, Sequelae of complication of pregnancy, childbirth, and the puerperium, since the ischemic cardiomyopathy developed as a result of the peripartum condition. The specific nature of the late effect/residual condition (i.e., ischemic cardiomyopathy) is sequenced first, followed by code O94.

Question:

A 57-year-old female presented for follow-up of several left shoulder issues, including shoulder impingement. When referencing “Impingement, joint” in the Alphabetic Index, there is an instructional note “see Disorder, joint, specified type NEC.” This indexing pathway leads to subcategory M25.81, Other specified joint disorders, shoulder. However, ICD-10-CM provides specific codes for shoulder impingement syndrome under subcategory M75.4, Impingement syndrome of shoulder, which can be found in the Alphabetic Index under “Syndrome,” “impingement, shoulder.” What is the accurate code assignment for shoulder impingement, not further specified?

Answer:

Assign code M25.812, Other specified joint disorders, left shoulder, for left shoulder impingement since the provider did not specifically document a diagnosis of “shoulder impingement syndrome” in a patient with a myriad of symptoms involving the left shoulder.

Shoulder impingement syndrome and shoulder impingement are not synonymous. Therefore, it would not be appropriate to assign a code from subcategory M75.4, Impingement syndrome of shoulder, unless the provider documents “shoulder impingement syndrome.”

Question:

A patient was admitted with a gunshot wound and active chest hemorrhage. An emergency left anterior thoracotomy was performed. The aorta was isolated and clamped with an aortic cross-clamp. The right side of the chest was opened with the same technique. The chest was explored and a large amount of active bleeding was encountered despite aortic cross clamping. Concurrent active resuscitation was performed, and multiple units of packed red cells were administered. Exploratory laparotomy revealed a large rent in the liver from posterior hepatic or inferior vena cava injury. Bleeding was determined uncontrollable, and resuscitative efforts ceased. Would it be appropriate to assign an ICD-10-PCS code for the aortic cross clamping - or is the clamping inherent to the exploratory thoracotomy? If reported, what is the correct body part value?

Answer:

Based on the documentation provided, aortic cross clamping is integral to the exploratory thoracotomy procedure performed to identify the cause of bleeding. As such, it is not separately reported.

Question:

A patient with an abdominal aortic aneurysm, renal artery stenosis and peripheral arterial disease presented for surgical repair of the aneurysm. The surgeon performed an open aneurysm repair with a bifurcated graft from the infrarenal aorta to the common iliac arteries.

After completion, a stenosis of the right iliac graft anastomosis was discovered. The patient was repositioned and percutaneous access was achieved through bilateral common femoral arteries. During placement of multiple stents to treat the stenosis of the anastomosis as well as renal arteries, a self-expanding stent was placed at the proximal aortic anastomosis to secure any atheromatous debris. What root operation is assigned for the stent to secure the atheromatous debris?

Answer:

Assign the following ICD-10-PCS code:

04H03DZ	Insertion of intraluminal device into abdominal aorta, percutaneous approach, for the stent placed to secure atheromatous debris.
----------------	---

Although stents are often used for dilation of a vessel, in this case, the stent was deployed to seal in the debris and prevent it from entering into the circulation. Per ICD-10-PCS guideline B6.1a, a device is coded if it remains after the procedure is completed.

Question:

A patient with a history of left breast cancer status post bilateral mastectomy and tissue expander placement presents for reconstructive surgery and removal of tissue expanders. The patient was found to have anterior capsule contractures on both sides. A greater degree of capsular contracture was found on the left side with elevation of tissue expander and breast contour on this side. Prior to reconstructive surgery, bilateral partial capsulectomies were performed by excising and removing the anterior capsules along with the tissue

expanders. What is the appropriate root operation for the partial capsulectomy? What are the appropriate ICD-10-PCS codes for the removal of bilateral tissue expanders?

Answer:

Assign the following procedure codes:

0HPT0NZ Removal of tissue expander from right breast, open approach; and

0HPU0NZ Removal of tissue expander from left breast, open approach, for the removal of the bilateral tissue expanders.

The partial capsulectomy procedures are inherent to the removal of the expanders and are not reported separately. This coding advice is based on the documentation for this case, in which both tissue expanders with their surrounding capsule were removed with no mention in the documentation of any additional steps that would indicate additional work or a more complex removal was required.

Question:

A patient presented for posterior L4-L5 lumbar spinal fusion. During the procedure, the FlareHawk™ expandable intervertebral cage broke upon insertion and expansion of the shell. The device was removed and a second FlareHawk™ cage was placed, which also broke during insertion. It was removed, and a titanium interbody cage was placed without incident for the posterior lumbar intervertebral fusion. What are the appropriate procedure code assignments for insertion and removal of the broken interbody fusion devices?

Answer:

Assign the following procedure code:

0SG00AJ Fusion of lumbar vertebral joint with interbody fusion device, posterior approach, anterior column, open approach for the lumbar intervertebral fusion with titanium interbody cage.

In this case, the procedure being performed was a spinal fusion procedure, therefore, only the code to identify the device that remained at the completion of the procedure is reported. It would not be appropriate to report an insertion and removal code for a spinal fusion procedure. The *ICD-10-PCS Official Guidelines for Coding and Reporting* for devices (B6.1a.) would not apply in this case. The guideline states, “If a device that is intended to remain after the procedure is completed requires removal before the end of the operative episode in which it was inserted (for example, the device size is inadequate or a complication occurs), both the insertion and removal of the device should be coded.”

Question:

A patient with respiratory failure underwent endotracheal intubation (ETT) for airway protection. The documentation states, “Utilization of a video-assisted laryngoscope with a #3 blade for direct visualization, with findings of “Grade 1 view with oral secretions.” Does the documentation of direct laryngoscopy support entry of instrumentation through a natural or artificial external opening “to reach and visualize the site of the procedure”? What is the correct approach value for the ETT intubation using video-assisted laryngoscopy? Does “Grade 1 view” affect code assignment?

Answer:

Assign the following procedure code:

0BH17EZ Insertion of endotracheal airway into trachea, via natural or artificial opening, for ETT intubation under direct visualization.

Video-assisted laryngoscopy is considered direct visualization and the documentation supports entry of instrumentation through a natural or artificial external opening “to reach the site of the procedure.” In video-assisted laryngoscopy, the ETT is placed under direct visualization with the assistance of a video monitor. The ETT is placed in the trachea; however, the laryngoscope does not enter the trachea, nor is the ETT delivered via the scope.

Grade 1 laryngoscopy describes the acquired view of the larynx. The grade does not refer to the condition, and does not affect code assignment.

Question:

A new device called preCARDIA is being used to treat acute decompensated heart failure (ADHF) patients. This new technology uses a balloon catheter and pump controller, designed to address ADHF via intermittent occlusion of the superior vena cava (SVC). These patients are brought into the cardiac suite, a Swan-Ganz catheter is advanced under direct fluoroscopic guidance into the distal pulmonary artery where measurements are obtained, and then the preCARDIA device is implanted in the superior vena cava (SVC) per research protocol. What is the appropriate ICD-10-PCS code for the insertion of a preCARDIA device? Is the objective of the procedure to occlude the SVC?

Answer:

Assign the following procedure code:

5A02110 Assistance with cardiac output using balloon pump, intermittent.

The objective of the preCARDIA device is to regulate the flow of blood into the heart from the SVC in patients with acute decompensated heart failure to prevent volume overload. The use of preCARDIA is appropriately coded using the root operation “Assistance.” Similar to an intra-aortic balloon pump (IABP), the preCARDIA balloon catheter and pump are not classified as a device under ICD-10-PCS.

Question:

A 28-year-old female status post pump and catheter exchange of her intrathecal baclofen system developed localized swelling in the lumbar wound. The surgeon noted, “No visible leak but orifice around emergence of catheter from deep adipose and fascia “moist” on Valsalva testing.” The provider’s final diagnostic statement listed, “Para-catheter cerebrospinal fluid (CSF) wound leak.” What is the appropriate code assignment for this leak?

Answer:

Assign code G96.09, Other spinal cerebrospinal fluid leak, for the para-catheter CSF wound leak. In this case, the leakage was around the catheter; however, the catheter itself was not leaking. Therefore, code T85.630A, Leakage of cranial or spinal infusion catheter, initial encounter, is not appropriate since the catheter was not leaking.

Question:

The above patient underwent wound exploration, creation of a more generous pocket and reposition of the intrathecal catheter. The provider ellipsed out the old incision, the anchor butterfly was relocated, resecured on each side, and sutured around the catheter soft tissue where it entered at the subcutaneous tissue and fascia. Next, on one side of the abdomen a more generous subcutaneous pocket was created with dissection to accommodate a stress relief loop of tubing already present within the wound. A soft tissue flap was created off the right side of the deep wound and folded over the emergence point of the catheter from the deep subcutaneous tissue and fascia, which was tacked down to try to secure the site of the leak repair. A second leaf of soft tissue was created and tacked down from the left side of the wound to support the initial buttressing layer. The deep subcutaneous tissue was then reapproximated. What is the correct root operation for this procedure?

Answer:

Assign the following procedures codes:

- | | |
|----------------|---|
| 0JW03Z | Revision of infusion device in trunk subcutaneous tissue and fascia, open approach, for the relocation and securing of the catheter into the trunk. |
| 0JQ80ZZ | Repair abdomen subcutaneous tissue and fascia, open approach, for the enlargement of the abdominal pocket and addition of flaps to both sides. |

Question:

A patient was admitted for treatment of metastatic melanoma, with tumor-infiltrating lymphocyte (TIL) therapy. Autologous TIL LN-145 infusion was administered via port-a cath every twelve hours over the next several days. TIL is an antineoplastic immunotherapy, in which the patient's lymphocytes are harvested, multiplied in a lab and then reinfused back into the patient. What is the appropriate ICD-10-PCS code assignment for the administration of TIL LN-145?

Answer:

Assign the following ICD-10-PCS code:

3E043GC Introduction of other therapeutic substance into central vein, for the TIL LN-145 administration via the port-a-catheter.

TIL LN-145 is an immunotherapy, which utilizes the cells of our immune system to eradicate cancer. While codes XW033L7, Introduction of Lifileucel immunotherapy into peripheral vein, percutaneous approach, new technology group 7 and XW043L7, Introduction of Lifileucel immunotherapy into central vein, percutaneous approach, new technology group 7 became effective October 1, 2021, to report the administration of Lifileucel (TIL LN-144), an autologous TIL cell therapy indicated for the treatment of patients with advanced melanoma, TIL LN-145 is a different TIL therapy. TIL LN-145 is not reported with the same codes as those used to report the administration of TIL LN-144 (Lifileucel).

Question:

A patient with left rear foot Charcot deformity and dislocation of the talonavicular and subtalar joints was admitted for percutaneous reduction and application of external ring fixator. The talus and talonavicular joints were reduced by pulling traction and a distal tibial ring and frame were placed to hold the reduction of the rear foot. A fragment allowed for further correction of the deformity, so pins were placed through the calcaneus, stabilized and tensioned to the ring. Additional pins were placed through the fifth metatarsal base into the navicular and through the medial cuneiform to the fifth metatarsal. An “old ring” was placed around the midfoot where wires were added and tensioned. Struts were placed from the tibial external fixator frame to the “old ring” of the midfoot. Traction on the “old ring” adducted the midfoot and forefoot to further decrease the deformity. Once the struts were stabilized, there was significant reduction of the rear foot joint talonavicular and subtalar joint deformity. What are the ICD-10-PCS codes for percutaneous reduction and placement of the external fixators?

Answer:

Assign the following procedure codes:

0SSJ35Z Reposition left tarsal joint with external fixation device, percutaneous approach, for placement of the external ring fixators to reduce and distract the talonavicular, subtalar and calcaneus joint deformities; and

0SSG35Z Reposition left ankle joint with external fixation device, percutaneous approach, for application of the external hinged fixator to distract the ankle.

Question:

A patient presents for treatment of a normal pressure hydrocephalus. The provider notes in the past medical history, "History of lymphoma, status post radiation and chemotherapy in remission." Since there is no unique code to capture lymphoma not further specified in remission, what is the correct code assignment for this condition?

Answer:

Assign code Z85.72, Personal history of non-Hodgkin lymphomas, for history of lymphoma in remission. This code assignment can be found in the Index as follows:

History

personal (of)
lymphoma (non-Hodgkin) Z85.72

ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.2, d, states, "When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."

Question:

A patient presents for preoperative medical evaluation, and the provider notes, in the past medical history, "History of non-Hodgkin lymphoma in remission with no evidence of disease (NED)." How is this diagnosis coded?

Answer:

Assign code Z85.72, Personal history of non-Hodgkin lymphomas, for a history of non-Hodgkin lymphoma in remission with NED. Complete remission is also referred to as NED.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.2, d, states, “When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.”

Announcement

Retirement of Nelly Leon-Chisen

We bid a fond farewell to Nelly Leon-Chisen who is retiring after nearly 30 years with the American Hospital Association (AHA). Her most recent position was AHA’s Executive Director of Coding & Classification and Executive Editor of *Coding Clinic*. We would like to express our sincere gratitude for her outstanding contributions to Health Information Management and coding professionals, as well as hospitals and health care systems. As a Cooperating Party for ICD-10-CM/PCS, she has developed national coding policy and guidelines, across all health care settings, in collaboration with the other Cooperating Parties, represented by the American Health Information Management Association (AHIMA); the Centers for Medicare and Medicaid Services (CMS); and the Centers for Disease Control and Prevention’s National Center for Health Statistics (CDC/NCHS). She is a subject matter expert and has presented on numerous coding topics, including quality, inpatient, outpatient, home health, rehabilitation hospitals, skilled nursing facilities, long-term care acute hospitals, observation care, clinical documentation, social determinants of health, etcetera. Although we will miss Nelly’s professionalism, grace and congeniality, her accomplishments serve to remind us of her influence, dedication, commitment and hard work.